STATE OF ILLINOIS
DEPARTMENT OF VETERANS' AFFAIRS
ILLINOIS VETERANS' HOMES

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of health information as described below concerning:

Name: _____Resident #:_____DOB:_____

Legal Authority For Request

_____I am the resident noted above.
_____I am the Power of Attorney for Health, Legal Guardian, or Executor/Administrator of the resident's estate.

Name & address of individual or organization to release information	Name & address of individual or organization to receive information
_____	_____
_____	_____
_____	_____

I would like the information disclosed in the following manner:

☐ Copies ☐ Review of record ☐ Verbal

The type and amount of information to be used or disclosed is as follows:

__ History and Physical
__ Immunization Records
__ Physician orders
__ Progress notes
__ Consultations
__ Social History
__ Stat Sheet
__ Mini-Mental Exam
__ Laboratory
__ EKG/Pacemaker
__ Radiology
__ TB results/treatments
__ Other_____
__ 3 months
__ 6 months
__ 1 year
__ Other

I understand that this may include the following information (check if applicable):

__ Sexually transmitted diseases.
__ Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).
__ Behavioral or mental health services.
__ Treatment for drug and/or alcohol abuse.

Purpose for which information is to be released:

_____

Records will not be released if this authorization is not signed and dated.
The authorization is voluntary.
I understand that this authorization may be revoked by written statement to the health information department at any time.
Unless revoked, the authorization will expire 60 days from the date of authorization or _____ (date), whichever occurs first.
If revoked, the revocation will not apply to information previously disclosed.
Information used or disclosed relevant to this authorization may be subject to re-disclosure and no longer protected by the privacy practices of this facility.
I agree to waive all claims against the facility for the release of requested information.
Unless sent to another health care provider, the facility will charge $5.00 retrieval fee plus $0.50 per page for copying fees.

Signature:_____ Date:_____

Authority if not resident:_____

Witness:_____ Date:_____

__ Copy of Authorization to Resident or Legal Representative

Date Released By Whom

_____ _____

Authorization requests may be sent to:

Privacy Officer
Illinois Veterans Home Quincy
1707 North 12th St.
Quincy, Il. 62301
217-222-8641 Ext. 337
Fax: 217-222-1375

Privacy Officer
Illinois Veterans' Home Manteno
One Veterans' Drive
Manteno, Il. 60950
815-468-6581 Ext. 243
Fax: 815-468-1088

Privacy Officer
Illinois Veterans' Home LaSalle
1015 O'Conor Avenue
LaSalle, Il. 61301
815-223-0303 Ext. 214
Fax: 815-220-0401

Privacy Officer
Illinois Veterans' Home Anna
792 North Main Street
Anna, Il.62906
618-833-6302
Fax: 618-833-3603